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ALTERNATIVE MEDICARE PHYSICIAN PAYMENTS FOR SURGERY SERVICES IN NON-OFFICE AMBULATORY SETTINGS

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I. INTRODUCTION

Under the current Medicare reimbursement system, as many as seven combinations of payment policies for ambulatory surgery exist across the three ambulatory places of service -- the physician's office, the hospital outpatient department (OPD), and the freestanding ambulatory surgical center (ASC). A physician is paid a global fee for an ambulatory surgical service provided in his or her office. This global fee contains payment both for the professional services of the physician and for the overhead costs of the physician's office. The physician's global fee is also intended to cover certain related services, post-operative visits for example, that are provided within a specified time period.

Generally, when an ambulatory surgical service is provided in either an OPD or an ASC, the physician receives the same global fee as if the service had been provided in his or her office. The OPD or ASC also receives a separate payment to cover its facility overhead costs. Most often, there is no reduction in the payment to the physician, even though the physician's global fee contains a payment for overhead costs. In effect, Medicare pays twice for overhead costs.

There are two exceptions to this payment scenario. The first is that ASCs only receive facility overhead payments for specific procedures approved by Medicare. For a non-approved procedure performed in an ASC only the physician receives a payment. The second exception is that the physician's payment for an OPD procedure that is commonly performed in physicians' offices should be capped at 60 percent of the office global fee, unless the OPD procedure is performed as an emergency service. This 60 percent limit for outpatient physician payments is intended to prevent the double payment of overhead costs by Medicare. However, it applies only to certain outpatient services, and it does not apply to any ASC services. In addition, the 60 percent limit, reportedly, has not been strictly applied.

Therefore, Medicare's payment system has double payments for facility overhead services built into it. This double payment apparently creates a financial incentive to shift services away from the office setting and to the OPD and ASC settings. The existence of this incentive has taken on even more importance given the upcoming adoption of a national Medicare physician fee schedule.

The Place of Service Payment Differentials project consists of three parts. The first is an examination of the characteristics of ambulatory surgery by place of service. The second is a measurement of the existing payment differentials across the three ambulatory settings. The third is an exploration of alternative approaches to payment for ambulatory surgery.

The first paper[1] reported the results of the first task, focusing on a descriptive analysis of surgery in the three ambulatory settings under study: physicians' offices, OPDs, and ASCs. The analysis relied on Medicare claims for physician services to describe which ambulatory surgical procedures are performed, where they are performed, and what physician specialties perform them. In addition, emergency department claims were examined in order to assess whether such services warrant separate treatment from non-emergency outpatient department claims.

The second paper[2] reported the results of the second task of the Place of Service Payment Differentials project. It was based on an analysis of payments for surgical procedures under the Medicare program in three ambulatory settings -- physicians' offices, hospital OPDs, and freestanding ASCs. The analysis relied on Medicare claims for physician and facility services to

[1]Colin Flynn and Margaret B. Sulvetta, "Descriptive Analysis of Surgery in Three Ambulatory Settings," Urban Institute Working Paper 6089-01, February 1991.

[2]Colin Flynn and Margaret B. Sulvetta, "Medicare Payment for Surgery in Three Ambulatory Settings," Urban Institute Working Paper 6089-02, April 1991.

explore the differences in procedure payments for certain high volume procedures by ambulatory setting and by characteristics such as geographic location and physician specialty.

This third paper focuses upon an analysis of alternative payment methods for physician services. It explores the effect of enforcing the 60 percent payment limit rule, extending the rule to emergency and ASC services, as well as the effect of moving to a Resource Based Relative Value System (RBRVS).

II. DATA SOURCES

The data used in this analysis are claims for physician services from the 1987 Part B Medicare Annual Data (BMAD) 5 percent beneficiary file. This BMAD file consists of all the Medicare Part B claims from a random five percent sample of Medicare's aged and disabled beneficiaries and 100 percent of Medicare's end-stage renal disease (ESRD) beneficiaries. The BMAD file includes claims from physicians, other non-physician providers (e.g., optometrists, chiropractors, chiropodists, social workers, physical therapists, etc.), independent laboratories, medical supply companies, ambulance services, clinics, and ambulatory surgical centers. These different providers are identified on the file by a type of provider code, specialty code, and in some instances, by the format of the provider identification number. The facility claims for ASC, for example, are required to contain six numeric digits, the first two of which are the state code, while physician IDs contain up to nine numbers and letters.

Records from the BMAD beneficiary file have a hierarchical structure based on the beneficiary. Each record may contain multiple line-items, with each line-item representing the provision of one or more of the same service to the same beneficiary by the same provider. Our analysis occurs at the service level by using line-items. We confined the analysis to those line-

items which represent a single service. Single service line-items were identified through the use of the MTU (Miles/Time/Units) indicator, selecting those line-items where only one service was performed. Throughout the discussion these single service line-items are referred to as physician claims.

Three separate subsets of the BMAD file, one for each of the ambulatory settings, are used in this analysis. The first step in this process was the identification of physician claims by place of service. The BMAD file contains a variable indicating the place of service which, unfortunately, is not reliable. Therefore, the straightforward method of creating analysis files for this project could not be followed. We have, in ongoing work for the Health Care Financing Administration, previously created two analytic files consisting of BMAD claims for physician services provided in OPDs and in ASCs. A third file, consisting of physician office claims, was created specifically for this analysis. The creation of these files is discussed briefly here, and will be discussed in greater detail in a later report.

Identification of Services Performed in Outpatient Departments

Services which are performed by office-based physicians (i.e., physicians who are not hospital employees) will have two components -- a professional (physician) component, and a technical (facility) component. Facility bills for the overhead costs of outpatient services are not contained in BMAD, but rather they comprise a separate Hospital Outpatient (HOP) claims file. We utilized information from the facility bills (HOP file) to help identify physician services provided in the outpatient setting (BMAD file). The facility bills were taken from the 1987 HOP file which contains all claims for hospital outpatient department facility services for the same five percent sample of beneficiaries as in the BMAD file. Since every claim for a physician service

in an OPD should have a matching claim from an OPD for the service provided, the OPD claims from the HOP file can be used to positively identify OPD claims on the BMAD file. Beneficiaries who were seen in a hospital OPD, including the emergency department, and then admitted into the hospital, were excluded from this analysis. The claims from the 1987 HOP were matched with 1987 BMAD claims using the beneficiary identification number and the date of service. A two day window around the date of service was used to identify additional claims that may have had a slight discrepancy in record keeping. Approximately one-quarter of a million BMAD physician claims for ambulatory surgical procedures were identified for 1987 using this method.

Identification of Services Performed in Ambulatory Surgical Centers

Claims for physician services in ASCs were identified directly from the 1987 BMAD file. Unlike the separate file for outpatient department facility claims, ASC facility claims are located in the BMAD file along with the physician claims. In theory, ASC facility and physician claims should be identifiable in BMAD by the place of service code. In addition, the ASC facility claims should be identifiable by the type of service code and the provider identification number as well. As noted earlier, ASC facilities are required to use a six digit provider ID that distinguishes them from physician providers. However, in practice, the ambulatory surgical centers do not adhere to the six digit ID requirement. Neither do ASCs accurately report the type of service code, which is used to designate ASC facility usage, or the place of service code. Furthermore, many ASCs and HCFA carriers also do not correctly report HCPCS (HCFA Common Procedure Coding System) procedure codes for the services performed. Instead, they frequently reported ASC facility services using ASC flat-rate billing codes. Therefore, none of

these indicators, taken alone, is sufficient to accurately identify ASC facility claims or physician services performed in an ASC. However, we have used all the available data items in an iterative process of identification, cross-checking, and discovery of additional means of identification, to find as many ASC facility and physician claims as possible. An internal BMAD match by beneficiary identification number and date of service was then performed using the identified facility and physician claims to find further claims. In addition, the internal match between facility and physician claims was used to change flat-rate billing codes to surgical procedure codes. Approximately 30,000 BMAD physician claims for ambulatory surgical procedures were identified for 1987 using this method.

Two shortcomings of the ASC file should be noted. First, the claims from the carriers for Puerto Rico and for railroad retirement beneficiaries were deleted during an early stage of file development. Second, the carrier serving both Arkansas and Louisiana failed to report most ASC facility claims. Claims for physician services in ASCs are present from both these states, but these physician claims could not be cross-checked with the matching ASC facility claims.

Identification of Services Performed in Physicians' Offices

To identify claims for services in physicians' offices there was little choice but to rely on BMAD place of service codes. The entire bill for services in physicians' offices, both the physician and facility fees, is found in the BMAD file as one claim for the "global fee." Claims for surgery in physicians' offices were identified using the office place of service code. One step was taken to clean this file of claims with incorrect place of service codes. This involved matching, by beneficiary identification number and date of service, the newly identified office claims against any claims positively identified as either OPD or ASC claims that also had a place

of service code for the physician's office. Any matching claims were then deleted from the office file. This step prevented the double counting of claims. Approximately 1.6 million BMAD physician claims for ambulatory surgical procedures were identified for 1987 using this method.

III. DEFINITION OF SURGICAL PROCEDURES

Surgical procedures are defined as those procedures coded in the HCPCS range 10000 to 69999. The HCPCS system consists of three parts: Level I, the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4), ranging from 00000 to 99999; Level II, HCFA's alphanumeric coding system, ranging from A0000 to V9999; and Level III, local carrier coding, ranging from W0000 to Z9999. For our purposes, the surgical range of 10000 to 69999 is identical in both the HCPCS and CPT-4 systems.

The surgical range of HCPCS contains many procedures that might not normally be considered surgery. This includes services such as drawing blood, catheterization, endoscopies, biopsies performed using needles, and the application of casts. HCFA examined this question in creating the regulations for ASCs and concluded that endoscopies and certain other invasive and manipulative procedures, while not necessarily involving incisions, were to be considered surgical procedures.[3]

How then to remove non-surgical procedures from the analysis? One way could be to identify procedures based on whether or not they are approved for performance in ambulatory surgical centers.

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[3]Federal Register, Volume 47, page 12591.

The Omnibus Reconciliation Act of 1980 (Public Law 96-499) authorized the extension of Medicare Part B benefits to freestanding ASCs. The Department of Health and Human Services was to determine which ambulatory procedures were to be covered. Determination of coverage is based on three factors, the safety of the procedure for performance on an ambulatory basis, the existence of a cost savings over performance of the procedure on an inpatient basis, and the lack of conflict with the provision of the procedure in the physicians' office setting. To satisfy the latter condition, procedures that were performed more than 50 percent of the time in physicians' offices were not eligible to be ASC-approved procedures.

The list of ASC-approved procedures could not be used to identify surgical procedures for two reasons. The first is coverage. Not all ambulatory surgical procedures are ASC-approved. Some are not approved because they could not be performed safely in ASCs. Other procedures are not approved because they would not have contributed to the shifting of care from inpatient to ambulatory settings. These procedures are either rarely performed on an inpatient basis or already frequently performed in physician offices. The second obstacle to use of the ASC-approved procedures list is that the list changes frequently, with hundreds of procedures having been added or removed since 1987.

Initial analysis of the BMAD physician claims discovered that one procedure, HCPCS 36415, routine venipuncture for collection of specimen(s), accounted for 38 percent of all surgical claims. This was the most common procedure in both the office and OPD settings, and the ninth most common procedure in the ASC. This code exists to provide a mechanism to reimburse the physician for collecting blood samples for laboratory analysis.

Lacking a coherent method for removing all procedures that are strictly non-surgical in nature, it was decided to delete the one blatantly non-surgical procedure, routine venipuncture,

and to make note of any other potentially non-surgical procedures as they arose. This step resulted in a decrease in the number of claims for ambulatory surgical procedures provided by physicians from 1.9 million to 1.2 million claims. Given that our files are from a five percent sample of Medicare beneficiaries, the 1.2 million claims represent approximately 24 million surgical claims from Medicare beneficiaries nationwide.

Among the remaining, non-venipuncture ambulatory surgery claims, the physician's office is by far the most dominant setting with nearly one million claims, for 80.7 percent of the total. The hospital outpatient setting is responsible for the bulk of the rest of the claims, almost 200,000 claims, and 16.8 percent of the total. Ambulatory surgical centers account for the remaining 30,000 claims, equal to 2.5 percent of the total number of surgery claims.

IV. PLACE OF SERVICE

As mentioned previously, BMAD place of service codes are considered to be unreliable. Overall, 84.2 percent of the claims had place of service office, 11.4 percent had place of service OPD, and 1.8 percent had place of service ASC (table 3). This is relatively close to the actual distribution of claims across the three settings (80.7 percent office, 16.8 percent OPD, and 2.5 percent ASC), but far from a perfect match.

Examining the place of service codes within each of the three ambulatory settings demonstrates the unreliability of the place of service coding. All of the office claims have place of service office, by definition. The office claims BMAD file was created using only the place of service code and screening for duplicate records.

However, only 63 percent of those claims identified through our matching process as OPD claims have place of service OPD. Most of the rest are identified as having occurred in the

office (20 percent), or in the inpatient hospital setting (13 percent). Since every one of these physician claims matches a claim from a hospital OPD, these claims should almost all have been coded as an OPD place of service. The 13 percent coded as place of service inpatient hospital are particularly likely to be coding errors, given that all beneficiaries subsequently admitted to a hospital have been removed from our database.

Ambulatory surgical center claims are even more diffuse than the OPD claims. Fifty-four percent have place of service ASC, 31 percent have place of service OPD, 6 percent have place of service office, and another 6 percent have place of service "other." In developing the ASC database it was observed that several carriers did not use the place of service ASC code, but rather, used the place of service "other" code for ASC claims. The large number of place of service OPD claims may result from confusion over the status of hospital owned or affiliated ASCs. Hospital-based ambulatory surgery units with clear administrative and financial delineation from the parent hospital elect whether to be reimbursed as hospital outpatient departments or freestanding ambulatory surgical centers. Their status may not be readily apparent to beneficiaries, to physicians, or to the physicians' billing staff.

Since 81 percent of all claims are from the office claims file, any measure using the entire set of ambulatory surgery claims will be heavily influenced by the trends of the office claims file. Therefore, while the place of service codes are within a few percentage points of the distribution of claims by ambulatory setting, they are not reliable across the three ambulatory settings. While 96 percent of the office coded claims are office claims, and 93 percent of the OPD coded claims are OPD claims, only 75 percent of the ASC coded claims are ASC claims. Therefore, relying too heavily on the BMAD place of service code does not appear to be prudent.

V. TYPE OF SERVICE

The BMAD type of service code divides services into broad categories such as medical care, surgery, anesthesiology, diagnostic lab, diagnostic x-ray, and numerous others. The type of service code appears to be far more reliable than the place of service code. Fully 99 percent of all the BMAD physician claims for ambulatory surgical procedures had a type of service code of surgery. An additional one-half of 1 percent of the claims had type of service assistance at surgery.

To further justify the removal of the routine venipuncture claims, we note that prior to their removal, 25 percent of all ambulatory surgery claims had type of service diagnostic lab. After the removal of the venipuncture claims, only one-tenth of one percent of the remaining ambulatory surgery claims had type of service diagnostic lab.

Unlike the place of service coding, the type of service coding exhibits little variation across the three ambulatory settings. Appropriately, type of service surgery dominates all three settings, and is coded for 99 percent of office claims, 97 percent of OPD claims, and 94 percent of ASC claims. The ASC setting has a number of claims coded type of service medical care (2 percent), and type of service diagnostic x-ray (1 percent). Both the OPD and the ASC settings have more claims coded type of service assistance at surgery (2 percent and 3 percent, respectively) than does the office setting (0.1 percent).

Identification of High Volume Procedures Common to All Settings

We had two concerns in identifying procedures for analysis -- to keep the number of claims up and to keep the number of procedures down. The best way to capture both the procedures that are common to all three settings and the procedures that are frequent in each

setting was to combine the 25 procedures common to all three settings and the ten most frequent procedures from each setting. Due to overlap among these groups of procedures, this method results in a total of 40 procedures.

These 40 procedures consist of: Twenty integumentary system (HCPCS range 10000-19999) procedures, which consist of 11 excision of skin lesion procedures, three destruction of skin lesion procedures, three debridement of nails procedures, and three other skin and nail procedures; three musculoskeletal system (HCPCS 20000-29999) procedures; six digestive system (HCPCS 40000-49999) procedures, all of which are gastrointestinal scope procedures; two urinary system (HCPCS 50000-53999) procedures, both of which are cystourethroscopy procedures; one nervous system (HCPCS 61000-64999) procedure; seven eye and ocular adnexa (HCPCS 65000-68999) procedures, which consist of four cataract removal procedures and three other eye procedures; and one auditory system (HCPCS 69000-69999) procedure.

VI. IDENTIFICATION OF COMMON OFFICE PROCEDURES

When a surgery is performed in an OPD the physician receives a payment for the professional component of the service which, according to current regulations, may be either the global fee as paid for the same service in the office setting or 60 percent of the global fee. The 60 percent limit applies to all OPD (including emergency department), services that are routinely (more than fifty percent of the time) performed in physicians' offices. An emergency department service that is a "bona fide emergency service" necessary to prevent the death or serious health impairment of the patient is exempt from the 60 percent rule. By definition, Medicare ASC-approved surgical procedures are not routinely provided in physicians' offices and therefore are exempt from the sixty percent professional fee limit.

HCFA publishes a list of the common office procedures which are subject to the sixty percent payment limit when performed in an OPD. That list of procedures is contained in Appendix A. The 40 top procedure codes listed above, contain 17 of the HCFA-identified common office procedures. Those 17 procedure codes are presented in Table 1. They constitute the set of procedures used in all subsequent analyses included here.

VII. CALCULATION OF PAYMENTS AND ADHERENCE TO THE SIXTY PERCENT RULE

With the procedure selection completed we now focus on the analysis of variations in payments for surgical procedures across place of service. The provider payment for a procedure is defined as the amount that Medicare stipulates should be paid for the service to the provider. This amount includes any beneficiary deductibles or coinsurance and excludes any balance billing.

For the physician's data from the BMAD file -- the physician's global fee for the office setting, and the physician's component for both the OPD and ASC settings -- the payment amount is the allowed charge. The physician's payment, recorded as the allowed charge, for all three settings is determined using the customary, prevailing, and reasonable charge screens by specialty and locality. One exception is that the physician's payment for non-emergency services provided in OPDs, that are commonly performed in physicians' offices, is subject to a charge limit screen. This limit applies only to certain outpatient services and, reportedly, has not been strictly applied.

When a physician performs a service in his office, he is paid a "global" amount which represents both the professional component of the service and the technical component or overhead (eg. utilities, nursing costs, etc.). When he performs the same service in an OPD, he

Table 1

Description of 17 Selected Routine Office Procedures

11000	Debridement of extensive eczematous or infected skin up to 10 percent of body surface
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure) unless otherwise listed
11440	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane lesion, diameter up to 0.5 centimeters
11442	Same as 11440, except lesion diameter 1.0 to 2.0 centimeters
11700	Debridement of nails, manual, five or less
11701	Debridement of nails, manual, each additional, five or less
11710	Debridement of nails, electric grinder, five or less
17000	Destruction by any method, with or without surgical curettement, all facial lesions or premalignant lesions in any location, including local anesthesia, one lesion
17001	Same as 17000, except second and third lesions, each
17100	Destruction by any method of benign skin lesions on any area other than the face, including local anesthesia, one lesion
20550	Injection, tendon sheath, ligament, trigger points or ganglion cyst
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa
45300	Proctosigmoidoscopy diagnostic (separate procedure)
45330	Sigmoidoscopy, flexible fiberoptic diagnostic
67210	Destruction of localized lesion of retina (e.g., maculopathy, choroidopathy, small tumors) one or more sessions
67228	Destruction of extensive or progressive retinopathy (e.g., diabetic retinopathy) one or more sessions
69210	Removal impacted cerumen (separate procedure) one or both ears

does not incur the overhead associated with his office practice. Those overhead costs are borne by the OPD and are reimbursed under a separate facility payment. Therefore, in order to avoid duplicate payments for overhead services, non-emergency physician services performed in the OPD are subject to a charge limit.

The charge base for this payment limit is set at the indexed prevailing for each service furnished by non-specialist physicians in office based practices in the charge locality where the hospital is located. If there is no non-specialist prevailing charge for the service, then the specialist prevailing charge screen will be used as the charge base.

Carriers then calculate the charge limit for each service by multiplying the charge base amount for each service by .60. The charge limit is then considered along with the billed amount, customary, prevailing and indexed prevailing in determining the reasonable amount. The charge limit is applied to all OPD, including emergency department, services that are routinely (more than fifty percent of the time) performed in physicians' offices. As noted earlier, an emergency department service that is a "bona fide emergency service" necessary to prevent the death or serious health impairment of the patient is exempt from the 60 percent rule. By definition, Medicare ASC-approved surgical procedures are not routinely provided in physicians' offices and therefore are exempt from the sixty percent professional fee limit.

In the task two paper, we used national mean procedure charges from non-emergency department OPD claims for 17 common office procedures to measure adherence to the 60 percent rule. Non-emergency department OPD claims were used to screen out the "bona fide emergency services" that would be exempt from the 60 percent rule. A substantial number of routine services are probably provided in the emergency department, but without access to clinical records there is no way to determine which emergency department services are routine and which

are life-saving. The 17 procedures presented here are those procedures among the 40 procedures used for prior analysis that also appear on a HCFA list of procedures that, nationally, are routinely provided in offices.[4]

Table 2 presents the mean national office global payments, the mean non-emergency department OPD physician payments, and the OPD payments as a percent of the office payments, for 17 common office procedures. The outpatient physician payments range from 88 percent of the office global for procedure 69210 removal of compacted ear wax to 129 percent of the office global for procedure 11442 excision of benign lesion. Only three of the procedures have OPD physician payments of less than 95 percent of the office global. Indeed, the median procedure is HCPCS 11100 skin biopsy with OPD physician payments of 105 percent of the office global.

As noted in the earlier paper, it appears that most carriers are not applying the 60 percent outpatient limit for common office procedures. Using national means obscured some of the variation, but if some carriers are applying the limit, they are most likely to be applying it to the three procedures where the OPD payment is less than 95 percent of the office payment, HCPCS 67210 destruction of retinopathy, 67228 destruction of retinal lesions, and 69210 removal of impacted ear wax.

For purposes of this analysis, we have refined the calculation of the charge limit. Rather than relying on national means for allowed charges, the 60 percent charge limit was calculated in the following manner. First, all office based physician claims for the selected 17 procedures were extracted. The BMAD file contains an indicator which identifies the limiting screen on the allowed amount, that is whether the allowed amount represents the billed, customary, prevailing,

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[4]Health Care Financing Administration, "Outpatient Limit on Physicians' Services," Program Memorandum: Carriers, Number B-90-8, November 1990.

Table 2

Adherence to the 60 Percent Outpatient Limit on
Physician Payments, Using National Charge Limits

HCPCS		Office Global Payment	Non-Emergency Outpatient Dept Physician Component	Physician Component as percent of Global
11000	Debridement	$29.97	$29.81	99.5%
11100	Biopsy of skin	42.77	44.75	104.6
11440	Excision of lesion	51.01	62.25	122.0
11442	Excision of lesion	81.21	104.94	129.2
11700	Debridement of nails	20.13	20.45	101.6
11701	Debridement of nails	16.32	17.74	108.7
11710	Debridement of nails	22.07	21.07	95.5
17000	Destruction of lesion	33.32	34.58	103.8
17001	Destruction of lesion	20.45	19.97	97.7
17100	Destruction of lesion	27.19	28.90	106.3
20550	Injection treatment	26.25	29.03	110.6
20610	Aspiration/injection, bursa	31.46	35.25	112.0
45300	Proctosigmoidoscopy	42.71	46.36	108.5
45330	Sigmoidoscopy	119.85	129.83	108.3
67210	Destruction of retinal lesion	767.87	707.42	92.1
67228	Destruction of retinopathy	791.23	736.16	93.0
69210	Removal of impacted ear wax	15.29	13.49	88.2

Source: Flynn and Sulvetta, "Medicare Payment for Surgery In Three Ambulatory Settings," Urban Institute Working Paper no. 6089-02, April 1991.

or indexed prevailing charge. We identified all claims where the indexed prevailing charge screen was the limiting screen. The indexed prevailing was the limiting screen for 43.4 percent of all claims. We then used these claims to calculate charge limits at the carrier level. Charge limits were set at 60 percent of the carrier level indexed prevailing charge for each of the seventeen procedures. Insufficient sample size precluded us from calculating the charge screen at the carrier locality level.

Table 3 compares the mean allowed charge for physician services delivered in the office with the mean allowed charge for physician services delivered in the hospital outpatient department, exclusive of emergency room claims. The number of claims in column 1 indicates the number of times the procedure was performed by a physician in the outpatient department. For example, procedure code 11000 skin debridement was performed 44 times in the outpatient department, based on the claims included in this sample. The average allowed charge for procedure 11000 when delivered in physicians' offices is $29.97. That same procedure, when delivered in the OPD has an average allowed charge of $29.79. The mean allowed charge for physician services delivered in the outpatient setting is actually higher than the mean charge for the same service delivered in the office setting for 11 of the 17 procedures. It is obvious from this comparison, that the 60 percent charge limit is not routinely applied to OPD services.

The average charge limit amounts for the 17 procedures are displayed in column 2. As noted above, the charge limit rules states that the allowed charge for physician services delivered in the outpatient department should be set at 60 percent of the minimum of the: billed charge, customary, prevailing, indexed prevailing, and the charge limit. A straightforward calculation of this is accomplished by taking the minimum of the allowed charge present on the BMAD physician claim and the 60 percent charge limit. The minimum of those two dollar amounts is

Charge Limit Table - Non-Emergency BMAD/OPD File

Procedure Code	No. of OPD Claims (1)	Mean Office Allowed Charges (2)	Mean Physician Allowed Charge in OPD (3)	Mean Physician OPD 60% Charge Limit (4)	Mean Minimum of 60% Charge Limit & Allowed Charge (5)	Column 3/ Column 5 (6)	Percent of Claims where 60% Charge is the Limiting Factor Screen (7)
11000	223	$29.967	$29.79	$20.58	$18.40	1.6667	93.72%
11100	885	42.774	44.80	28.43	27.78	1.6132	87.68
11440	335	51.012	62.43	40.50	38.08	1.6598	78.81
11442	260	81.215	105.70	68.35	64.60	1.6293	78.85
11700	177	20.130	20.62	13.71	13.40	1.5186	87.01
11701	161	16.320	17.86	11.62	11.13	1.6225	86.34
11710	144	22.069	21.04	13.99	13.54	1.5503	87.50
17000	609	33.321	34.64	22.81	21.65	1.5893	77.01
17001	261	20.445	19.92	15.02	13.16	1.5149	66.28
17100	290	27.187	28.96	20.10	18.90	1.5044	72.76
20550	199	26.250	29.08	18.33	17.55	1.6261	86.93
20610	581	31.462	35.35	22.36	21.88	1.6054	90.36
45300	892	42.709	46.45	27.87	27.49	1.6848	95.63
45330	2,690	119.849	130.20	79.40	73.34	1.7756	86.69
67210	449	767.868	707.89	437.12	433.86	1.6444	96.66
67228	1,204	791.225	738.08	491.78	477.28	1.5632	91.11
69210	142	15.293	13.55	11.06	9.56	1.4065	66.90

the payment amount which physicians would have received if the charge limit screen had been applied as required. Column 5 displays the allowed charge with the 60 percent rule applied. Column 6 displays the ratio of actual allowed charges to the calculated screened charges. For 16 of the 17 procedures, the actual allowed charge paid to the physician by Medicare is 150 percent or more of the allowed charge after incorporating the 60 percent charge screen. The smallest difference is evident for procedure code 69210 removal of impacted ear wax with a mean actual allowed charge of $13.55, and an estimated screened allowed charge of $11.06. The largest difference is found for procedure 45330 sigmoidoscopy which has an actual mean allowed charge of $130.20, and a screened allowed charge of $73.34.

Column 7 displays the percentage of claims for which the charge screen was the limiting factor in calculating the allowed charge. (That is the minimum of the actual allowed charge and the 60 percent charge limit was the charge limit.) The percent of claims subject to the charge screen as the limiting factor ranges from roughly 66 percent for procedures 17001 destruction, lesion and 69210 removal of impacted ear wax to almost 94 percent for procedure code 11000 skin debridement. It is obvious from the percentages in column 7 that the 60 percent charge rule is infrequently applied. If the 60 percent charge limit had been applied to the 6,832 claims included in this simulation, Medicare payments would have been reduced by $670,078.

VIII. EXTENSION OF THE SIXTY PERCENT RULE TO EMERGENCY SERVICES

As previously noted, bona fide emergency services are excluded from the 60 percent charge limit rule. Without access to medical records we cannot determine which of the services delivered in an emergency room were "bona fide" emergencies. Thus we excluded from the previous analysis (Table 3) any claims which included a revenue center charge in an emergency

room revenue center. Table 4 explores the effect of extending the 60 percent rule to services delivered in the emergency room setting. As shown in column 1, the number of occurrences of these procedures in the emergency room is relatively small. The most frequently performed procedure is 45330 sigmoidoscopy, with 542 claims. Five of the 17 procedures were performed less than 20 times in an emergency room (ER) setting.

Table 4, column 2 displays the mean allowed global charge, that is the mean charge for each procedure performed in a physicians' office. Column 3 displays the mean allowed charge from the BMAD claims, for those physician services delivered in an emergency room. The allowed charges range from $14.14 for procedure code 11710 nail debridement to $671.12 for 67210, destruction of retinal lesion. For 8 of the 17 procedures the average ER charge exceeds the average physicians' office allowed charge. However, a comparison with table 3 shows that the average allowed charges for services delivered in the emergency room are generally lower than when those same services are delivered in the non-emergency OPD setting. Twelve of the 17 procedure codes have average non-emergency allowed charges above the ER allowed charges.

Column 4 displays the 60 percent charge limit screens for the 17 selected procedures.[5] The charge screens range from a low of $9.76 for procedure code 11701 nail debridement to a high of $439.02 for procedure code 67210 destruction of retinal lesion. Column 5 displays the allowed charge which would have been paid to physicians if the 60 percent rule were applied to emergency room services. (Column 5 is calculated as the mean of the lesser of the existing allowed charge on the BMAD bills and the 60 percent charge screen.) In those instances where

[5]It should be recalled that these charge limits were calculated as 60% of the carrier procedure level prevailing charge for services delivered in a physicians' office setting. Thus, the charge screens for tables 3, 4 (and 5) were calculated off the same base, with a constant set of claims. These charge limits were then merged to the claims for OPD nonemergency and emergency services (and in table 5, for ASC services) by carrier and procedure code. The reason that the charge screens in table 4 (emergency room claims) differ from the charge screens in table 3 (OPD nonemergency claims) is that the mix of carriers represented by the emergency and nonemergency claims differs.

Table 4

Charge Limit Table - Emergency BMAD/OPD File

Procedure Code	No. of ER Claims (1)	Mean Office Allowed Charges (2)	Mean Physician Allowed Charge in ER (3)	Mean Physician ER 60% Charge Limit (4)	Mean Minimum of 60% Charge Limit & Allowed Charge (5)	Column 3/ Column 5 (6)	Percent of Claims where 60% Charge is the Limiting Factor Screen (7)
11000	44	$29.97	$37.59	$26.60	$24.80	1.6610	95.46%
11100	26	42.77	40.56	25.55	25.55	1.6102	100.00
11440	35	51.01	56.52	36.30	33.02	1.5945	71.43
11442	48	81.22	102.59	66.82	64.41	1.6513	85.42
11700	9	20.13	18.58	13.12	12.56	1.4439	88.89
11701	3	16.32	19.13	9.76	9.76	2.1722	100.00
11710	7	22.07	14.14	13.54	12.39	1.1250	71.43
17000	24	33.32	29.64	24.69	21.89	1.3395	58.33
17001	11	20.44	17.46	14.82	12.16	1.3856	54.54
17100	16	27.19	27.73	18.71	17.94	1.5252	87.50
20550	31	26.25	25.12	16.78	16.25	1.5237	93.55
20610	111	31.46	36.83	22.83	22.54	1.6334	95.60
45300	260	42.71	43.49	27.38	27.16	1.6050	95.77
45330	542	119.85	114.28	79.87	68.90	1.6782	79.52
67210	27	767.87	671.12	439.02	435.29	1.5608	96.30
67228	76	791.22	592.40	408.72	397.16	1.4948	86.84
69210	59	15.29	19.97	12.35	12.09	1.6274	93.22

the procedure was performed infrequently (e.g., procedure codes 11100 and 11701) the new average allowed charge equals the 60 percent charge limit.

Column 6 presents the ratio of the old allowed charge to the new allowed charge incorporating the 60 percent charge limit. The allowed charge without the charge limit is shown to range from 113 percent (procedure 11710 nail debridement) to 217 percent (procedure 11701 nail debridement) of the allowed charge which does incorporate the charge limit. The 60 percent charge screen was the limiting factor in the simulated allowed charge calculation ranging from 55 percent of all claims for procedure code 17001 to 100 percent of all claims for procedure codes 11100 and 11701. Across the 1,218 claims included in this simulation, Medicare payments would have been reduced by a total of $56,480 dollars if the 60 percent charge limit had been applied.

IX. EXTENDING THE SIXTY PERCENT RULE TO SERVICES IN THE ASC

Since the 60 percent payment limit has been applied only to those procedures which are performed at least 50 percent of the time in the physicians' office, ASC-approved procedures have been, by definition, exempt from the 60 percent charge limit rule. However, Table 5 displays the effect of extending the charge limit to physician services delivered in ambulatory surgery centers.

As shown in Table 5, these services are delivered with very low frequency. Procedure code 67228 exhibits the highest frequency with 180 claims. Seven of the 17 procedures were provided twenty or fewer times in the ASC.

A comparison of columns 2 and 3 shows that the mean physician allowed charge for procedures performed in the ASC is lower than the comparable average charge for procedures performed in the physicians' office for 11 of the 17 procedures. The mean allowed charge for

Table 5

Charge Limit Table - ASC Surgeon File

Procedure Code	No. of ASC Claims (1)	Mean Office Allowed Charges (2)	Mean Physician Allowed Charge in ASC (3)	Mean Physician ASC 60% Charge Limit (4)	Mean Minimum of 60% Charge Limit & Allowed Charge (5)	Column 3/ Column 5 (6)	Percent of Claims where 60% Charge is the Limiting Factor Screen (7)
11000	6	$29.97	$28.05	$16.05	$16.05	1.7396	100.00%
11100	19	42.77	35.02	25.40	23.86	1.4908	73.68
11440	117	51.01	50.09	30.96	28.27	1.6841	72.34
11442	78	81.22	90.27	52.64	48.00	1.8636	75.64
11700	116	20.13	22.21	15.45	15.35	1.4192	84.78
11701	30	16.32	18.40	14.87	14.47	1.2620	70.00
11710	22	22.07	26.68	17.21	17.21	1.5500	100.00
17000	40	33.32	19.75	22.45	15.11	1.2325	47.50
17001	20	20.44	15.39	12.01	10.95	1.3660	70.00
17100	17	27.19	22.10	16.23	14.23	1.4820	64.71
20550	14	26.25	22.02	15.30	14.55	1.5310	85.71
20610	10	31.46	24.12	20.74	18.72	1.2312	50.00
45300	10	42.71	42.40	27.50	27.08	1.5381	90.00
45330	103	119.85	143.50	77.10	75.74	1.8736	90.29
67210	34	767.87	650.41	493.42	429.48	1.4435	73.53
67228	180	791.22	671.45	438.59	422.30	1.5790	93.33
69210	24	15.29	22.68	15.76	15.15	1.5236	83.33

the ASC site of care ranges from a low of $22.02 for procedure code 20550 to a high of $671.45 for procedure code 67228. A comparison with Table 3 shows that for all but 5 of the procedures, the average allowed charge in the ASC site is lower than the comparable average charge for services delivered in the OPD.

Column 4 includes the mean 60 percent charge screen applicable to the ASC services. Column 5 presents the average allowed charge when the 60 percent charge limit is included in allowed charge calculations. The new average allowed charge exactly equals the 60 percent charge limit for procedures 11000 and 11710. As shown in column 6, the ratio of the existing allowed charge to the calculated allowed charge which incorporates the 60 percent charge limit ranges from 1.23 for procedures 17000 and 20610 to 1.87 for procedure 45330. Column 7 shows that the 60 percent screen was the limiting factor in the allowed charge calculation ranging from 47.5 percent of all claims for procedure code 17000 to 100 percent of all claims for procedure codes 11000 and 11710. Across the 700 claims included in this simulation, Medicare savings of $65,486 would have been recognized if the 60 percent charge limit screen were applied to the physicians services delivered in the ASC.

X. THE RESOURCE BASED RELATIVE VALUE SYSTEM

The prior analysis was based on the physician payment system in effect in 1987, the year represented by our claims file. As previously described, that system calculated allowed charge amounts as 80 percent of the minimum of the billed, customary, prevailing and indexed prevailing charges. The payment limit for routine office services delivered in an OPD was set at the minimum of that allowed charge and the 60 percent charge limit, which, in turn, was

calculated as .6 times the nonspecialist indexed prevailing charge at the carrier, locality, procedure level.

Beginning in January 1992, the existing CPR-based (customary, prevailing, reasonable) payment system was replaced by a system using resource based relative values (RBRVS). There are three components to the RBRVS payment system: (1) the relative value for the service, which is a national value for each procedure code; (2) the geographic adjustment factor (GAF), which varies at the carrier locality level (called the geographic practice cost index, or GPCI); and (3) the nationally uniform dollar conversion factor. There are separate relative values and geographic adjustment factors for three components of the total service. These three components include physician work (wk), practice costs or overhead (pc), and malpractice insurance costs (mc). Using this approach, the payment for a given procedure in a given locality is calculated as:

$$(RVU_{wk}*GPCI_{wk}) + (RVU_{pc}*GPCI_{pc}) + (RVU_{mc}*GPCI_{mc}) * CF$$

The RBRVS system also incorporates a site of service payment differential. Those procedures that are primarily provided in office settings are subject to a payment limit if they are performed in outpatient departments. For those procedures, the practice cost RVU is reduced by 50 percent. Payment is then set at the minimum of the billed charge or the reduced fee schedule amount. The limit is applied only to the practice cost component of the fee schedule amount, to reflect the lower practice costs incurred in the outpatient department. The current exemption for emergency services has been eliminated unless they bill an emergency room code. Thus the practice cost limitation applies to both emergency and non-emergency outpatient services. Under this regulation, the fee schedule amounts for routine office services provided in an OPD are set at:

$$(RVU_{wk}*GPCI_{wk}) + ((RVU_{pc}* .5)*GPCI_{pc}) + (RVU_{mc}*GPCI_{mc}) * CF$$

Calculating RBRVS Payment Amounts

While the previous analysis provides us with an estimate of the effects of adhering to the CPR payment limitation for outpatient services, and extending the rule to services delivered in the ASC, the next logical question is what effects would be observed under the Medicare fee schedule. In order to address this question, we calculated fee schedule amounts for the 17 routine office procedures included above.

The RVS and GPCI values and 1992 CF were taken from the published RBRVS final rules.[6] The conversion factor for 1992 of $31.001 was obtained by updating the 1991 conversion factor by an annual update factor of 1.9 percent. However, since we are basing our simulation on 1987 claims, the conversion factor must be deflated back to 1987 using the annual updates.[7] The update factors are as follows:

Period	Percent Increase
4/1/88-12/31/88	1.0
1/1/89-3/31/90	1.0
4/1/90-12/31/90	2.0
1/1/91-12/31/91	0.0
1/1/92-12/31/92	1.9

Thus the conversion factors for the period 1987-1992 are as follows:

Period	Conversion Factor
1/1/87-12/31/87	$29.239
1/1/88-12/31/88	29.531
1/1/89-12/31/89	29.826
1/1/90-12/31/90	30.423
1/1/91-12/31/91	30.423
1/1/92-12/31/92	31.001

The conversion factor applied to the 1987 physician claims was $29.239.

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[6]Federal Register, November 25, 1991, addendum B and addendum C.

[7]Since each of the 17 procedure codes is in the CPT-4 surgery procedure range, the relevant update factors come from the "other services" category as opposed to the "primary care" series.

XI. RBRVS PAYMENTS BY SITE OF CARE

The effect of moving to a resource based relative value payment system is displayed in Table 6. Column 1 displays the RBRVS payment amount for those services. This payment amount is calculated as described above, and as noted, reflects the full relative values. Average payment ranges from $12.32 for procedure code 17001 to $517.25 for procedure code 67228. It is interesting to contrast these payment amounts with the mean payment amounts for physician office services calculated using the CPR payment approach. Under the CPR payment system, physician allowed charges ranged from $17.88 for procedure 11701 to $729.43 for procedure 67228. Average payment amounts under the RBRVS system are lower than under the CPR system for 13 of the 17 procedures.[8]

Column 2 in Table 6 presents the fee schedule amounts incorporating the reduced practice cost relative values. After reducing the practice cost RVUs by 50 percent, the fee schedule amounts for the 17 procedures range from $9.15 for procedure 17001 to $364.70 for procedure 67228. Column 3 displays the payment rate for those routine office services delivered in an OPD. The payment is calculated as the minimum of the reduced fee schedule, or the billed charge. Average payments range from $9.00 for procedure 17001 to $363.78 for procedure 67228.

Column 5 displays the ratio of the fee schedule amounts for physicians' office services relative to the reduced fee schedule amounts. The full fee schedule amounts range from a low of 1.28 times the reduced fee schedule for procedure 20610 to 1.48 for procedure 69210. Column 6

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[8]While these payment amounts are very close similar to the mean OPD payment amounts included in table 3, they are not exactly equal because the two tables are based on a different number of claims. This difference is due to the exclusion of railroad retirement claims from the RBRVS simulation. No GPCI factors were available for the railroad retirement carrier, therefore, those claims were excluded from the RBRVS analysis. They were, however, included in the analysis presented in table 3.

RBRVS Table - 1987 BMAD/OPD File

Procedure Code	Office RBRVS Fee (1)	RBRVS Fee with 50% Reduced Practice Cost RVU (2)	Minimum of Reduced Fee and Billed Charge (3)	Allowed Charge for Phsyician Services Delivered in the OPD (4)	Column 1/ Column 3 (5)	Column 4/ Column 3 (6)	Percent of Claims where the Reduced Fee is the Limiting Factor (7)
11000	$42.20	$35.47	$31.94	$31.08	1.3210	0.9730	65.17%
11100	36.70	28.29	28.00	44.68	1.3108	1.5956	95.61
11440	56.42	45.53	43.27	61.87	1.3040	1.4299	83.78
11442	93.99	75.58	72.32	105.22	1.2996	1.4549	86.04
11700	20.34	15.49	15.22	20.52	1.3359	1.3482	90.33
11701	14.87	11.24	11.08	17.88	1.3416	1.6130	92.07
11710	20.40	15.28	14.89	20.72	1.3704	1.3920	87.42
17000	33.66	26.97	25.79	34.45	1.3050	1.3356	84.99
17001	12.32	9.15	9.00	19.82	1.3691	1.2035	95.22
17100	28.87	23.10	21.94	28.90	1.3157	1.3168	85.95
20550	48.94	42.36	35.22	28.55	1.3894	1.8104	49.56
20610	39.76	32.67	31.15	35.59	1.2762	1.1424	79.62
45300	41.34	31.98	31.66	45.78	1.3058	1.4460	96.70
45330	74.09	52.66	52.40	127.53	1.4139	1.4337	97.90
67210	496.63	353.35	352.46	705.81	1.4090	1.0025	99.16
67228	517.25	364.70	363.78	729.43	1.4218	1.0051	98.44
69210	26.18	22.89	17.72	15.43	1.4778	1.8712	46.77

shows that the ratio of previous allowed charges to the reduced fee schedule amounts ranges from 0.81 for procedure 20550 to 2.43 for procedure 45330. The reduced fee schedule amount was the limiting payment factor for 47 percent of the claims for procedure 69210, and 99 percent of the claims for procedure 67210 (column 7). Across the 10,831 outpatient physician claims included in this simulation, the total dollars which could have been saved by transition from the old allowed amounts to the reduced RVS amounts is $928,692.

XII. EXTENDING REDUCED RBRVS AMOUNTS TO ASC SERVICES

The regulations for reduction in fee schedule payments do not cover services delivered in an ambulatory surgery center. The basic premise for payment reduction for services delivered in an outpatient department is that non-reduction would result in duplicate payments for overhead. Since routine office based procedures are not included on the ASC approved procedures list, no facility payment would be made to ASCs for those procedures. Therefore, even though the physician is paid for such services, this does not result in duplicate overhead payments. However, although double compensation for overhead costs is not an issue, the physician would still be paid for practice costs which he did not incur, since the ASC provided the overhead resources, but the fee schedule amount recognizes the physicians' overhead expenses. We have therefore chosen to examine the effect of extending the fee schedule payment limitation to physician services delivered in the ASC. Table 7 presents the results of that analysis.

Column 1 displays the RBRVS payment amount for routine services delivered in an office setting. This payment amount reflects the full relative values. As noted in the discussion of Table 6, average payment ranges from $12.32 for procedure code 17001 to $517.25 for procedure

RBRVS Table - 1987 ASC File

Procedure Code	Office RBRVS Fee (1)	RBRVS Fee with 50% Reduced Practice Cost RVU (2)	Minimum of Reduced Fee and Billed Charge (3)	Allowed Charge for Phsyician Services Delivered in the ASC (4)	Column 1/ Column 3 (5)	Column 4/ Column 3 (6)	Percent of Claims where the Reduced Fee is the Limiting Factor (7)
11000	$42.20	$34.90	$32.06	$28.05	1.3160	0.8747	66.67%
11100	36.70	27.63	27.32	35.02	1.3435	1.2819	94.74
11440	56.42	44.77	42.64	50.09	1.3234	1.1748	80.85
11442	93.99	74.51	69.19	90.27	1.3583	1.3046	84.62
11700	20.34	14.84	14.71	22.21	1.3825	1.5099	91.30
11701	14.87	10.55	10.55	18.40	1.4094	1.7442	100.00
11710	20.40	15.27	15.27	26.68	1.3363	1.7471	100.00
17000	33.66	26.39	18.90	19.75	1.7808	1.0447	45.00
17001	12.32	8.78	8.31	15.39	1.4822	1.8529	85.00
17100	28.87	22.64	19.57	22.10	1.4752	1.1292	76.47
20550	48.94	41.23	31.49	22.02	1.5543	0.6994	0.00
20610	39.76	32.55	29.83	24.12	1.3327	0.8084	80.00
45300	41.34	31.49	31.31	42.40	1.3205	1.3545	90.00
45330	74.09	50.99	50.97	143.50	1.4537	2.8156	99.03
67210	496.63	341.22	326.93	650.41	1.5190	1.9894	82.35
67228	517.25	353.13	344.13	671.45	1.5030	1.9511	94.44
69210	26.18	22.18	20.29	22.68	1.2904	1.1182	75.00

code 67228. Column 2 in Table 7 presents the fee schedule amounts incorporating the reduced practice cost relative values. After reducing the practice cost RVUs by 50 percent, the fee schedule amounts for the 17 procedures range from $8.78 for procedure 17001 to $353.13 for procedure 67228. Column 3 displays the payment rate for those routine office services delivered in an ASC. The payment is calculated as the minimum of the reduced fee schedule or the billed charge. Average payments range from $8.31 for procedure 17001 to $344.13 for procedure 67228. Column 4 presents the allowed charge for physician services delivered in an ASC.

Column 5 displays the ratio of the fee schedule amounts for physicians' office services relative to the reduced fee schedule amounts. The full fee schedule amounts range from a low of 1.29 times the reduced fee schedule for procedure 69210 to 1.78 for procedure 17000. The reduced fee schedule amount was the limiting payment factor for none of the claims for procedure 20550, and 99 percent of the claims for procedure 45330 (column 7). Column 6 shows that the ratio of previous allowed charges to the reduced fee schedule amounts ranges from 0.81 for procedure 20610 to 2.82 for procedure 45330. Across the 700 ASC physician claims included in this simulation, the total dollars which could have been saved by transition from the old allowed amounts to the reduced RVS amounts is $82,584.

XIII. CONCLUSIONS

This paper has used Medicare claims data to examine the extent of adherence to current Medicare physician payment regulations, as well as the effect of adopting alternative payment strategies. It has examined payment policies for physician services delivered in three ambulatory settings -- the physician's office, the hospital outpatient department (OPD), and the freestanding ambulatory surgical center (ASC).

When Medicare services are delivered in a physician's office, the physician receives a global payment which incorporates reimbursement for practice costs or overhead (e.g., nursing staff, supplies, etc.) When services are delivered in an outpatient department, a separate facility payment is made, which incorporates compensation for the facility's overhead expenses. Therefore, in order to avoid double compensation for overhead expenses, physician reimbursement for services delivered in an outpatient department are subject to a charge limit screen. This screen is applied only to a specified list of procedures which are routinely performed in a physician's office. "Bona fide" emergency services delivered in an outpatient setting are exempt from the charge limit screen.

The charge limit base is the non-specialist indexed prevailing for the carrier locality where the hospital outpatient department is located. This charge base is then multiplied by .6 to calculate the applicable charge screen. The physician's reasonable charge is then set at the minimum of the billed, customary, prevailing, indexed prevailing, and charge limit. For purposes of this analysis, we have approximated the charge limit screen by multiplying the physician's carrier level prevailing charge by .6.

This charge limit screen was then applied to physician's claims for 17 procedures included in HCFA's list of services routinely provided in an office setting. These 17 procedures were selected from a list of 40 procedures identified in a previous working paper. Those 40 procedures include 25 procedures that were among the 100 most frequently provided procedures in each of the three ambulatory settings, and the ten most frequently provided procedures from each of the three settings (there were 15 overlapping procedures). These 40 procedures captured 52 percent of all office surgery claims, 53 percent of all OPD single-coded physician surgery claims and 70 percent of all ASC physician surgery claims.

The most important finding is that there is little indication that the 60 percent charge limit is being followed. The mean allowed charge for physician services delivered in an outpatient setting was actually higher than the allowed charge for the same service delivered in an office setting for 11 of the 17 procedures, excluding facility fees paid to OPD and ASCs. For 16 of the 17 procedures, the actual allowed charge paid to the physician by Medicare carriers was 150 percent or more of the allowed charge if the charge limit had been applied.

We then explored the effect of extending the 60 percent charge limit rule to emergency services. Without access to medical records it is not possible to determine which services delivered in an emergency room were truly life threatening. Therefore, all claims with a charge in an emergency room revenue center were excluded from the previous analysis. (Emergency room claims were identified by matching physician claims with OPD facility claims and examining the revenue center charges on the facility bill.) These previously excluded claims were used to simulate the impact of extending the 60 percent rule to emergency services. The average allowed charge for physician services delivered in an emergency room setting were higher than comparable allowed charges for services delivered in the office, for 8 of the 17 selected procedures. When the 60 percent charge limit was incorporated into the calculation of an allowed charge, the charge screen was the limiting factor ranging from 54 percent of all claims for one procedure to 100 percent of all claims for two other procedures.

The 60 percent charge limit has never applied to physician services delivered in an ambulatory surgery center. We simulated the effect of extending the limit to services delivered in that site of care. The mean physician allowed charge for services provided in an ASC was lower than the comparable allowed charges for physician office services for 11 of the 17

procedures. However, the 60 percent charge screen was still the limiting factor ranging from 47.5 percent of services for one procedure to 100 percent of all claims for two other procedures.

The Resource Based Relative Value System

To this point, the discussion has centered upon the Medicare payment system in effect prior to 1992. That system was based on a customary, prevailing, reasonable charge (CPR) approach relevant to the 1987 claims data used in this analysis. However, beginning in January 1992, the existing CPR system was replaced by a Resource Based Relative Value System (RBRVS). The RBRVS consists of relative values which vary at the procedure level, geographic adjustment factors, which vary at the procedure, carrier, locality level, and a national dollar conversion factor. The relative values used in the calculation of payment rates include three components -- physician work, practice costs or overhead, and malpractice insurance costs. The RBRVS incorporates reduction in physician payments to avoid double compensation for overhead costs. Under the RBRVS, the practice cost relative value is reduced by 50 percent when a physician provides a routine office service in an outpatient department. Physicians are then paid the minimum of the reduced fee schedule amount and the billed charge. The RBRVS also eliminated the exclusion for emergency services.

We examined the effect of the RBRVS fee reduction approach by simulating what physician payments would have been if the RBRVS system had been in effect in 1987. (The 1992 conversion factor was deflated to 1987 levels.) Average payment amounts for services delivered in a physician's office were lower under the RBRVS than under the CPR system for 13 of the 17 procedures.

The final simulation included in this analysis involved extension of the reduced RBRVS fees to physician services provided in an ASC. The ratio of previous CPR allowed charges to reduced RBRVS amounts ranged from 0.81 to 2.82.

APPENDIX A

Procedure Codes Subject to the Outpatient Limit

HCPCS*	Description
10040	ACNE SURGERY
10060	DRAINAGE OF SKIN ABSCESS
10061	DRAINAGE OF SKIN ABSCESS
10080	DRAINAGE OF PILONIDAL CYST
10120	REMOVE FOREIGN BODY
10121	REMOVE FOREIGN BODY
10140	DRAINAGE OF HEMATOMA
10141	DRAINAGE OF HEMATOMA
10160	PUNCTURE DRAINAGE OF LESION
11000	SURGICAL CLEANSING OF SKIN
11001	ADDITIONAL CLEANSING OF SKIN
11040	SURGICAL CLEANSING, ABRASION
11041	SURGICAL CLEANSING OF SKIN
11042	CLEANSING OF SKIN/TISSUE
11050	TIM SKIN LESION
11051	TRIM 2 TO 4 SKIN LESIONS
11052	TRIM OVER 4 SKIN LESIONS
11100	BIOPSY, EACH ADDITIONAL LESION
11200	REMOVAL OF SKIN TAGS
11201	REMOVAL OF ADDED SKIN TAGS
11400	REMOVAL OF SKIN LESION
11401	REMOVAL OF SKIN LESION
11402	REMOVAL OF SKIN LESION
11403	REMOVAL OF SKIN LESION
11404	REMOVAL OF SKIN LESION
11420	REMOVAL OF SKIN LESION
11421	REMOVAL OF SKIN LESION
11422	REMOVAL OF SKIN LESION
11423	REMOVAL OF SKIN LESION
11424	REMOVAL OF SKIN LESION
11440	REMOVAL OF SKIN LESION
11441	REMOVAL OF SKIN LESION
11442	REMOVAL OF SKIN LESION
11443	REMOVAL OF SKIN LESION
11444	REMOVAL OF SKIN LESION
11446	REMOVAL OF SKIN LESION
11600	REMOVAL OF SKIN LESION
11601	REMOVAL OF SKIN LESION
11602	REMOVAL OF SKIN LESION
11603	REMOVAL OF SKIN LESION
11604	REMOVAL OF SKIN LESION
11620	REMOVAL OF SKIN LESION
11621	REMOVAL OF SKIN LESION
11622	REMOVAL OF SKIN LESION
11623	REMOVAL OF SKIN LESION
11624	REMOVAL OF SKIN LESION
11640	REMOVAL OF SKIN LESION
11641	REMOVAL OF SKIN LESION
11642	REMOVAL OF SKIN LESION
11643	REMOVAL OF SKIN LESION
11644	REMOVAL OF SKIN LESION
11700	SURGICAL CLEANSING OF NAILS
11701	SURGICAL CLEANSING OF NAILS
11710	SURGICAL CLEANSING OF NAILS
11711	SURGICAL CLEANSING OF NAILS

APPENDIX A

Procedure Codes Subject to the Outpatient Limit

HCPCS*	Description
11730	REMOVAL OF NAIL PLATE
11731	REMOVAL OF SECOND NAIL PLATE
11732	REMOVE NAIL PLATE, ADDITIONAL
11740	DRAIN BLOOD FROM UNDER NAIL
11750	REMOVAL OF NAIL BED
11760	RECONSTRUCTION OF NAIL BED
11762	RECONSTRUCTION OF NAIL BED
11765	EXCISION OF NAIL FOLD, TOE
11900	INJECTION INTO SKIN LESIONS
11901	SKIN LESION INJECTIONS, ADDITIONAL
13100	REPAIR OF WOUND OR LESION
13101	REPAIR OF WOUND OR LESION
13131	REPAIR OF WOUND OR LESION
13132	REPAIR OF WOUND OR LESION
13150	REPAIR OF WOUND OR LESION
14000	SKIN TISSUE REARRANGEMENT
14020	SKIN TISSUE REARRANGEMENT
14040	SKIN TISSUE REARRANGEMENT
15851	REMOVAL OF SUTURES
16000	INITIAL TREATMENT OF BURN(S)
16010	TREATMENT OF BURN(S)
16020	TREATMENT OF BURN(S)
16025	TREATMENT OF BURN(S)
17000	DESTRUCTION OF FACE LESION
17001	DESTRUCTION OF ADDED LESIONS
17002	DESTRUCTION OF ADDED LESIONS
17010	DESTRUCTION SKIN LESION(S)
17100	DESTRUCTION OF SKIN LESION
17101	DESTRUCTION OF 2ND LESION
17102	DESTRUCTION OF ADDED LESIONS
17104	DESTRUCTION OF SKIN LESIONS
17105	DESTRUCTION OF SKIN LESIONS
17110	DESTRUCTION OF SKIN LESIONS
17200	ELECTROCAUTERY OF SKIN TAGS
17201	ELECTROCAUTERY ADDED LESIONS
17250	CHEMICAL CAUTERY OF WOUND
17304	CHEMOSURGERY OF SKIN LESION
17305	2ND STAGE CHEMOSURGERY
17306	3RD STAGE CHEMOSURGERY
17307	FOLLOW-UP SKIN LESION THERAPY
17310	EXTENSIVE SKIN CHEMOSURGERY
17340	CRYOTHERAPY OF SKIN
17360	SKIN PEEL THERAPY
19000	DRAINAGE OF BREAST LESION
19100	BIOPSY OF BREAST
20000	INCISION OF ABSCESS
20500	INJECTION OF SINUS TRACT
20520	REMOVAL OF FOREIGN BODY
20550	INJECTION TREATMENT
20600	DRAINAGE JOIN/BURSA/CYST

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Procedure Codes Subject to the Outpatient Limit

HCPCS*	Description
20605	DRAINAGE JOIN/BURSA/CYST
20610	INJECT/DRAIN JOINT/BURSA
20615	TREATMENT OF BONE CYST
20670	REMOVAL OF SUPPORT IMPLANT
21030	REMOVAL OF FACE BONE LESION
21040	REMOVAL OF JAW BONE LESION
23066	BIOPSY SHOULDER TISSUES
24650	TREAT RADIUS FRACTURE
25500	TREAT FRACTURE OF RADIUS
25600	TREAT FRACTURE RADIUS/ULNA
26010	DRAINAGE OF FINGER ABSCESS
26600	TREAT METACARPAL FRACTURE
26605	TREAT METACARPAL FRACTURE
26720	TREAT FINGER FRACTURE, EACH
27520	TREAT KNEECAP FRACTURE
27780	TREATMENT OF FIBULA FRACTURE
27786	TREATMENT OF ANKLE FRACTURE
28001	DRAINAGE OF BURSA OF FOOT
28010	INCISION OF TOE TENDON
28090	REMOVAL OF FOOT LESION
28108	REMOVAL OF TOE LESIONS
28124	PARTIAL REMOVAL OF TOE
28126	PARTIAL REMOVAL OF TOE
28153	PARTIAL REMOVAL OF TOE
28160	PARTIAL REMOVAL OF TOE
28190	REMOVAL OF FOOT FOREIGN BODY
28230	INCISION OF FOOT TENDON(S)
28232	INCISION OF TOE TENDON
28234	INCISION OF FOOT TENDON
28270	RELEASE OF FOOT CONTRACTURE
28272	RELEASE OF TOE JOINT, EACH
28285	REVISION OF HAMMERTOE
28298	CORRECTION OF BUNION
28308	INCISION OF METATARSAL
28400	TREATMENT OF HEEL FRACTURE
28470	TREAT METATARSAL FRACTURE
28475	TREAT METATARSAL FRACTURE
28490	TREAT BIG TOE FRACTURE
28510	TREATMENT OF TOE FRACTURE
28515	TREATMENT OF TOE FRACTURE
29065	APPLICATION OF LONG ARM CAST
29075	APPLICATION OF FOREARM CAST
29085	APPLY HAND/WRIST CAST
29105	APPLY LONG ARM SPLINT
29125	APPLY FOREARM SPLINT
29126	APPLY FOREARM SPLINT
29130	APPLICATION OF FINGER SPLINT
29200	STRAPPING OF CHEST
29260	STRAPPING OF ELBOW OR WRIST
29345	APPLICATION OF LONG LEG CAST

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Procedure Codes Subject to the Outpatient Limit

HCPCS*	Description
29355	APPLICATION OF LONG LEG CAST
29365	APPLICATION OF LONG LEG CAST
29405	APPLY SHORT LEG CAST
29425	APPLY SHORT LEG CAST
29435	APPLY SHORT LEG CAST
29440	ADDITION OF WALKER TO CAST
29515	APPLICATION LOWER LEG SPLINT
29520	STRAPPING OF HIP
29530	STRAPPING OF KNEE
29540	STRAPPING OF ANKLE
29550	STRAPPING OF TOES
29580	APPLICATION OF PASTE BOOT
29700	REMOVAL/REVISION OF CAST
29705	REMOVAL/REVISION OF CAST
30100	INTRANASAL BIOPSY
30110	REMOVAL OF NOSE POLYP(S)
30200	INJECTION TREATMENT OF NOSE
30210	NASAL SINUS THERAPY
30901	CONTROL OF NOSEBLEED
31000	IRRIGATION MAXILLARY SINUS
31250	NASAL ENDOSCOPY, DIAGNOSTIC
31505	DIAGNOSTIC LARYNGOSCOPY
31525	DIAGNOSTIC LARYNGOSCOPY
31575	FIBERSCOPIC LARYNGOSCOPY
36400	ESTABLISH ACCESS TO VEIN
36425	ESTABLISH ACCESS TO VEIN
36470	INJECTION THERAPY OF VEIN
36471	INJECTION THERAPY OF VEINS
36500	INSERTION OF CATHETER, VEIN
38505	NEEDLE BIOPSY, LYMPH NODE(S)
40490	BIOPSY OF LIP
40808	BIOPSY OF MOUTH LESION
40810	EXCISION OF MOUTH LESION
40812	EXCISE/REPAIR MOUTH LESION
41100	BIOPSY OF TONGUE
41108	BIOPSY OF FLOOR OF MOUTH
41112	EXCISION OF TONGUE LESION
42100	BIOPSY ROOF OF MOUTH
42330	REMOVAL OF SALIVARY STONE
42650	DILATION OF SALIVARY DUCT
42800	BIOPSY OF THROAT
45300	PROCTOSIGMOIDOSCOPY
45302	PROCTOSIGMOIDOSCOPY
45303	PROCTOSIGMOIDOSCOPY
45305	PROCTOSIGMOIDOSCOPY; BIOPSY
45310	PROCTOSIGMOIDOSCOPY
45330	SIGMOIDOSCOPY
45355	SURGICAL COLONOSCOPY
46050	INCISION OF ANAL ABSCESS
46083	INCISE EXTERNAL HEMORRHOID

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HCPCS*	Description
46221	LIGATION OF HEMORRHOID(S)
46230	REMOVAL OF ANAL TABS
46320	REMOVAL OF HEMORRHOID CLOT
46500	INJECTION INTO HEMORRHOIDS
46600	DIAGNOSTIC ANOSCOPY
46602	DIAGNOSTIC ANOSCOPY
46604	ANOSCOPY AND DILATION
46614	ANOSCOPY; CONTROL BLEEDING
46900	DESTRUCTION, ANAL LESION(S)
46934	DESTRUCTION OF HEMORRHOIDS
46936	DESTRUCTION OF HEMORRHOIDS
46945	LIGATION OF HEMORRHOIDS
50690	INJECTION FOR URETER X-RAY
51700	IRRIGATION OF BLADDER
51705	CHANGE OF BLADDER TUBE
51720	TREATMENT OF BLADDER LESION
52000	CYSTOSCOPY
52281	CYSTOSCOPY AND TREATMENT
53600	DILATE URETHRA STRICTURE
53601	DILATE URETHRA STRICTURE
53620	DILATE URETHRA STRICTURE
53621	DILATE URETHRA STRICTURE
53660	DILATION OF URETHRA
53661	DILATION OF URETHRA
53670	INSERT URINARY CATHETER
54235	PENILE INJECTION
55000	DRAINAGE OF HYDROCELE
55700	BIOPSY OF PROSTATE
56501	DESTRUCTION, VULVA LESION(S)
56600	BIOPSY OF VULVA
57100	BIOPSY OF VAGINA
57160	INSERTION OF PESSARY
57452	EXAMINATION OF VAGINA
57454	VAGINA EXAMINATION & BIOPSY
57500	BIOPSY OF CERVIX
57505	ENDOCERVICAL CURETTAGE
57510	CAUTERIZATION OF CERVIX
57511	CRYOCAUTERY OF CERVIX
58100	BIOPSY OF UTERUS LINING
58102	CURETTAGE OF UTERUS LINING
59420	CARE BEFORE DELIVERY
60100	BIOPSY OF THYROID
61070	BRAIN CANAL SHUNT PROCEDURE
64400	INJECTION FOR NERVE BLOCK
64405	INJECTION FOR NERVE BLOCK
64413	INJECTION FOR NERVE BLOCK
64415	INJECTION FOR NERVE BLOCK
64418	INJECTION FOR NERVE BLOCK
64420	INJECTION FOR NERVE BLOCK
64425	INJECTION FOR NERVE BLOCK

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HCPCS*	Description
64440	INJECTION FOR NERVE BLOCK
64441	INJECTION FOR NERVE BLOCK
64445	INJECTION FOR NERVE BLOCK
64450	INJECTION FOR NERVE BLOCK
64505	INJECTION FOR NERVE BLOCK
64550	APPLY NEUROSTIMULATORY
64565	IMPLANT NEUROELECTRODES
64640	INJECTION TREATMENT OF NERVE
65205	REMOVE FOREIGN BODY FROM EYE
65210	REMOVE FOREIGN BODY FROM EYE
65220	REMOVE FOREIGN BODY FROM EYE
65222	REMOVE FOREIGN BODY FROM EYE
65430	CORNEAL SMEAR
65435	CURETTE/TREAT CORNEA
66761	REVISION OF IRIS
66762	REVISION OF IRIS
67031	LASER SURGERY, EYE STRANDS
67105	REPAIR, DETACHED RETINA
67141	TREATMENT OF RETINA
67145	TREATMENT OF RETINA
67208	TREATMENT OF RETINAL LESION
67210	TREATMENT OF RETINAL LESION
67228	TREATMENT OF RETINAL LESION
67505	INJECT/TREAT EYE SOCKET
67515	INJECT/TREAT EYE SOCKET
67700	DRAINAGE OF EYELID ABSCESS
67800	REMOVE EYELID LESION
67801	REMOVE EYELID LESIONS
67810	BIOPSY OF EYELID
67820	REVISE EYELASHES
67825	REVISE EYELASHES
67840	REMOVE EYELID LESION
67850	TREAT EYELID LESION
67921	REPAIR EYELID DEFECT
68020	INCISE/DRAIN EYELID LINING
68110	REMOVE EYELID LINING LESION
68200	TREAT EYELID BY INJECTION
68440	INCISE TEAR DUCT OPENING
68700	REPAIR TEAR DUCTS
68760	CLOSE TEAR DUCT OPENING
68800	DILATE TEAR DUCT OPENING(S)
68820	EXPLORE TEAR DUCT SYSTEM
68830	REOPEN TEAR DUCT CHANNEL
68840	EXPLORE/IRRIGATE TEAR DUCTS
69000	DRAIN EXTERNAL EAR LESION
69020	DRAIN OUTER EAR CANAL LESION
69100	BIOPSY OF EXTERNAL EAR
69200	CLEAR OUTER EAR CANAL
69210	REMOVE IMPACTED EAR WAX
69220	CLEAN OUT MASTOID CAVITY

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Procedure Codes Subject to the Outpatient Limit

HCPCS*	Description
69222	CLEAN OUT MASTOID CAVITY
69400	INFLATE MIDDLE EAR CANAL
69401	INFLATE MIDDLE EAR CANAL
69420	INCISION OF EARDRUM
69433	CREATE EARDRUM OPENING
69610	REPAIR OF EARDRUM
92002	EYE EXAM & TREATMENT, NEW
92004	EYE EXAM & TREATMENT, NEW
92012	EYE EXAM & TREATMENT, ESTB.
92014	EYE EXAM & TREATMENT, ESTB.
92018	EYE EXAM & TREATMENT, NEW
92020	SPECIAL EYE EVALUATION
92060	SPECIAL EYE EVALUATION
92065	ORTHOPTIC/PLEOPTIC TRAINING
92070	FITTING OF CONTACT LENS
92081	VISUAL FIELD EXAMINATION(S)
92082	VISUAL FIELD EXAMINATION(S)
92083	VISUAL FIELD EXAMINATION(S)
92100	SERIAL TONOMETRY EXAM(S)
92120	TONOGRAPHY & EYE EVALUATION
92130	WATER PROVOCATION TONOGRAPHY
92140	GLAUCOMA PROVOCATIVE TESTS
92225	EXTENDED OPHTHALMOSCOPY, NEW
92226	EXTENDED OPHTHALMOSCOPY
92230	OPHTHALMOSCOPY/ANGIOSCOPY
92235	OPHTHALMOSCOPY/ANGIOGRAPHY
92270	ELECTRO-OCULOGRAPHY
92275	ELECTRORETINOGRAPHY
92280	SPECIAL EYE EVALUATION
92283	COLOR VISION EXAMINATION
92284	DARK ADAPTATION EYE EXAM
92286	INTERNAL EYE PHOTOGRAPHY
92311	SPECIAL CONTACT LENS FITTING
92312	SPECIAL CONTACT LENS FITTING
92352	SPECIAL SPECTACLES FITTING
92353	SPECIAL SPECTACLES FITTING
92504	EAR MICROSCOPY EXAMINATION
92506	SPEECH & HEARING EVALUATION
92507	SPEECH/HEARING THERAPY
92511	NASOPHARYNGOSCOPY
92516	FACIAL NERVE FUNCTION TEST
93797	CARDIAC REHAB
93798	CARDIAC REHAB/MONITOR
95831	LIMB MUSCLE TESTING, MANUAL
95832	HAND MUSCLE TESTING, MANUAL
95833	BODY MUSCLE TESTING, MANUAL
95834	BODY MUSCLE TESTING, MANUAL
95851	RANGE OF MOTION MEASUREMENTS
95852	RANGE OF MOTION MEASUREMENTS
95857	TENSILON TEST

APPENDIX A

Procedure Codes Subject to the Outpatient Limit

HCPCS*	Description
96440	CHEMOTHERAPY, INTRACAVITARY
99201	OFFICE & OTHER OUTPATIENT, NEW PATIENT, LEVEL 1
99202	OFFICE & OTHER OUTPATIENT, NEW PATIENT, LEVEL 2
99203	OFFICE & OTHER OUTPATIENT, NEW PATIENT, LEVEL 3
99204	OFFICE & OTHER OUTPATIENT, NEW PATIENT, LEVEL 4
99205	OFFICE & OTHER OUTPATIENT, NEW PATIENT, LEVEL 5
99211	OFFICE & OTHER OUTPATIENT, ESTAB PATIENT, LEVEL 1
99212	OFFICE & OTHER OUTPATIENT, ESTAB PATIENT, LEVEL 1
99213	OFFICE & OTHER OUTPATIENT, ESTAB PATIENT, LEVEL 1
99214	OFFICE & OTHER OUTPATIENT, ESTAB PATIENT, LEVEL 1
99215	OFFICE & OTHER OUTPATIENT, ESTAB PATIENT, LEVEL 1
A2000	MANIPULATION OF SPINE BY CHIROPRACTOR
H5300	OCCUPATIONAL THERAPY
MOOO5	OFFICE VISITS W/ 2 OR MORE MODALITIES TO THE SAME AREA
M0006	OFFICE VISITS W/ 1 OF THE ABOVE MENTIONED TREATMENT
M0007	OFFICE VISIT INC. COMBINATION OF ANY MODALITY(S) AND
M0008	OFFICE VISIT INC. COMBINATION OF ANY MODALITY(S) AND
M0101	CUTTING OR REMOVAL OF CORNS, CALLUSES AND/OR TRIMMING OF NAILS, APPLICATION
M0702	BRIEF, OSTEOPATHIC MANIPULATIVE THERAPY PERFORMED IN OFFICE, OR
M0704	LIMITED, OSTEOPATHIC MANIPULATIVE THERAPY PERFORMED
M0706	INTERMEDIATE OSTEOPATHIC MANIPULATIVE THERAPY PERFORMED
M0708	EXTENDED OSTEOPATHIC MANIPULATIVE THERAPY PERFORMED
M0710	COMPREHENSIVE OSTEOPATHIC MANIPULATIVE THERAPY PERFORMED

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